STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055004	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH BROOK REST HOME	1611 NORTH BROOK III SHCOOL ROAD VALE, NC 28168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey June 6-7, 2023.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had a resident assessment completed	D 254		

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D 254	Continued From page 1	D 254		

annually.

The findings are:

Review of Resident #2's current FL2 dated 11/25/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease, respiratory failure, and dementia.
-The resident had an order for continuous oxygen.
-The resident was semi-ambulatory and required assistance with bathing and dressing.

Review of Resident #2's care plan dated 01/20/21 revealed:
-Resident #2 required limited assistance with eating, ambulation, and transferring.
-He required extensive assistance with toileting, bathing, dressing, and grooming.

Review of Resident #2's record revealed there were no care plans after 01/20/21 available for review.

Interview with the Supervisor-in-Charge (SIC) on 06/06/23 at 12:30pm and on 06/07/23 at 10:23am revealed:
-She or the Administrator were responsible for ensuring care plans were completed within 30 days of admission, annually and if there was a significant change in the resident's condition.
-It was possible Resident #2's current care plan had been removed from the resident's record and moved to an achieve folder.
-She thought Resident #2 had a current care plan, but she was unable to locate it.
-She tried to complete chart audits for care plans monthly.
-She completed a chart audit in May 2023, but

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D 254	Continued From page 2 she must have overlooked Resident #2 current care plan. Interview with the Administrator on 06/07/23 at 11:34am revealed: -The SIC or the co-administrator were responsible for ensuring care plans were completed as required. -He thought chart audits were completed routinely but he was unsure how often they were done.	D 254		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) related to a medication to decrease inflammation (swelling). The findings are: Review of Resident #2's current FL2 dated 11/25/22 revealed diagnoses included chronic obstructive pulmonary disease (COPD)(lung disease) and respiratory failure. Review of the facility's Drug Management Policy	D 358		

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D 358	Continued From page 3	D 358		

dated 06/17/02 revealed a record of medications given to each resident would be kept and would include:
- The resident's name
- The name, strength, and quantity of medication
- Instructions for administering the medication
- The date and time the medication was administered
- The name or initials of the person who administered the medication

Review of Resident #2's Emergency Department (ED) after visit summary dated 04/30/23 revealed:
-He was seen in the ED for shortness of breath and chest pain.
-He was prescribed prednisone (a medication used to decrease inflammation) 20mg, three tablets once daily for four days.

Review of Resident #2's April 2023 and May 2023 Medication Administration Records (MARs) revealed there was no entry for prednisone.

Interview with a Pharmacist with the facility's contracted pharmacy on 06/06/23 at 4:53pm revealed:
-Prednisone 20mg, twelve tablets were dispensed on 05/01/23 for Resident #2.
-Resident monthyly MARs were printed a few days prior to the end of each month and delivered to the facility so staff had time to review them and make any necessary changes before using the MAR on the first day of the month.
-The facility staff would have needed to entered Resident #2's order for prednisone on his May 2023 MAR because it would not have been printed on it.

Interview with Supervisor-in-Charge (SIC) on 06/07/23 at 10:23am revealed:

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D 358	Continued From page 4 -It was the responsibility of the staff member who received a new medication order to write it on the resident's MAR. -She thought she administered all four doses of prednisone 20mg, three tablets daily to Resident #2. -She was unsure why she did not write the prednisone order on Resident #2's MAR. -The omission of Resident #2's prednisone order on the MAR should have been identified each time the medication was administered. Interview with Resident #2's Primary Care Physician (PCP) on 06/07/23 at 10:46am revealed: -Resident #2 was seen in the ED on 04/30/23 for an acute exacerbation (sudden worsening of symptoms) of COPD. -He was prescribed prednisone to decrease inflammation in his lungs. -He expected the facility to document all medications administered. -He would re-educate facility staff on proper documentation of medication administration. Interview with the Administrator on 06/07/23 at 11:34am revealed: -The staff member receiving new medication orders was to write the medication on the resident's MAR. -If a staff member needed to administer a medication that was not on the resident's MAR, they were responsible to add it to the MAR. -MAR audits were completed by the SIC or the co-administrator, but he was unsure how often they were completed.	D 358		